

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-049118

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 317

Primary Registration District No. 547

Registrar's No. 3628

FILED JAN 10 1963

1. PLACE OF DEATH

a. COUNTY

St. Louis

b. CITY (If outside corporate limits, give TOWNSHIP only)
OR TOWN Richmond HeightsLength of stay in 1b
13 daysc. FULL NAME OF (If NOT in hospital, give location)
HOSPITAL OR INSTITUTION St. Mary's HospitalInside Limits
Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE Illinois b. COUNTY St. Clair

c. CITY OR TOWN Belleville

Inside Limits
Yes ☒ No ☐d. STREET ADDRESS (If outside, give location)
8 No. 15th St.Reside on Farm
Yes ☐ No ☒3. NAME OF DECEASED
(Type or print)

First

Middle

Last

Vada

Barbara

Shaffer

4. DATE OF DEATH

Month December

Day 11

Year 1962

5. SEX

Female

6. COLOR OR RACE

White

7. Married ☒ Never Married ☐
Widowed ☐ Divorced ☐

8. DATE OF BIRTH

7/31/1916

9. AGE (last birthday)

46

IF UNDER 1 YEAR IF UNDER 24 HR
Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Cleaner & Dye House Worker

10b. KIND OF BUSINESS OR INDUSTRY

Cleaning Co.

11. BIRTHPLACE (City and state or country)

Sherman, Texas

12. CITIZEN OF WHAT COUNTRY

U.S.

13a. FATHER'S NAME

William R. Bryant

13b. MOTHER'S MAIDEN NAME

Ludia L. Weems

14. NAME OF HUSBAND OR WIFE

Ernest W. Shaffer

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give war or dates of serv)

No

16. SOCIAL SECURITY NO.

17. INFORMANT
Address Ernest W. Shaffer, Belleville, Ill.

18. CAUSE OF DEATH (Enter only one cause per line)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Ruptured Cerebral Aneurysm

INTERVAL BETWEEN ONSET AND DEATH
18 days

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b)

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days.

☐ Yes ☒ No ☐ Unknown19. WAS AUTOPSY PERFORMED?
YES ☐ NO ☐20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY
Hour a.m. p.m.

Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐
NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from 11-28-62 to 12-11-62 and last saw her alive on 12-11-62
Death occurred at 7:30 pm m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Degree or title)

22b. ADDRESS

22c. DATE SIGNED

23a. BURIAL, CREMATION, REMOVAL (Specify)

Removal

23b. DATE

12-13-62

23c. NAME OF CEMETERY OR CREMATORY

Forest Park Cemetery

23d. LOCATION (City, town, or county)

Shreveport, La.

(State)

24. FUNERAL DIRECTOR

ADDRESS

Gaerdner Funeral Home, Belleville, Ill.

25. DATE RECD. BY LOCAL REG.

12-13-62

26. REGISTRAR'S SIGNATURE

John C. Murphy M.D.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed _____

John M. Baker

Licensed Embalmer No. _____

298294

P. O. Address _____

East St. Louis, Ill

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.